State of Arizona Health Care Services Organization/Hospital, Medical, Dental, Optometric Service Corporation/Prepaid Dental Plan Transmittal and Certification Form

NAIC# _____

Company Name _____

Company Address _____

_____

_____

Contact Person _____

Telephone Number _____

This Filing is : Individual Group
And Is : New Resubmission

(Note: Resubmissions must include copy of original disapproval letter.)

For Department of Insurance Use Only

Date received_____ Analyst_____

	Date	Initials
Approved	_____	_____
Filed _____	_____	_____
Disapproved	_____	_____
Withdrawn	_____	_____
Acknowledge Receipt	_____	_____
Other_____	_____	_____

Exempt With ARS No

List all forms included in this filing.

Form Number	Name	Replaces
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If additional space is required, please attach a separate sheet.

Type Of Filing (check all that apply):

Contract Endorsement/Rider/Amendment

Rate Evidence of Coverage

Medicare+Choice Medicare Select

Vision Care Dental

Prepaid Dental Disclosure Form

Information Packet

Other _____

Company Officer Certification

I have reviewed or supervised the review of the above forms. To the best of my knowledge and belief they are in conformance with applicable provisions of Title 20, Chapter 6 of the Arizona Revised Statutes, Chapter 20 of the Arizona Administrative Code and applicable orders by the Director of Insurance. I also acknowledge responsibility for the validity, accuracy and completeness of transmittal and enclosures in this filing.

_____
Signature of Company Officer/Health Plan Corporate Officer

_____ _____
Typed Name and Title Date

P-107(HC) Rev. 11/00